Advances in Technology in the Addiction Profession, Part VI: Using Mobile Apps for Treating Co-occurring Eating & Substance Use Disorders

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My name is Jessie O'Brien the training and professional develop contact manager here at NAADAC the Association for addiction professionals, I will be the facilitator for this training experience the permanent homepage for NAADAC webinars is NAADAC.org/webinars so bookmark this page to get the latest.

Closed captioning is provided by CaptionAccess, if you check the chat box you see the link.

We are using Zoom webinar for today's event and I like to draw your attention to two features in Zoom webinar and one in Zoom webinar that is not in Zoom meetings but the chat box which some of you have discovered, feel free to use it throughout the webinar today, chat about and let us know where you are coming from today and the second is the Q&A box which I love, any questions or our presenter you can type them in the Q&A box and if you have any questions or us as well feel free to type them in the Q&A box and we can answer.

I like to point out if you have questions put them in the Q&A box because if you write them in the chat they get lost in the scrolling.

If we see a question, in the chat box, we will ask you to put it in the Q&A box.

When you see questions you like in the Q&A you can upvote them helps cure the questions, we put a link to the slides and also user-friendly instructional guide to access our online CE quiz get your CE certificate.

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if you need your certificate to say livedo the sequence in the next 24 hours.
Let's meet our presenter, Elissa Chakoff Martinez is the Clinical Implementation Manager at Recovery Record and Recovery Path, in digital therapeutics develops clinical best practices and oversees review of clinical product requirements; Martinez is a licensed marriage and family therapist and qualified clinical supervisor, currently working towards her Doctoral degree in counseling.

She has clinical and managerial experience working at the residential, PHP, IOP, and outpatient levels of care, specializing in the treatment of eating disorders, co-occurring substance use disorders, and family counseling.

If you want to turn your camera and meet yourself can join us for today and I'm going to stop sharing my screen and let her share from her is.

>> ELISSA MARTINEZ: Thank you Jessie and NAADAC for having me today I will share my screen today and thank you for that wonderful introduction as well.

I'm excited to be here to talk about using apps in your work with clients with co-occurring eating disorders and substance use disorders and as just mentioned I have experience working with this population so I'm excited to share some of my examples in working with clients and suggestions and implementation of mobile apps which I think has been applicable for quite a long time but even more so timely in the last year.

I'm looking forward to your questions at the end.

Today we will focus on these made objectives, discussing effective methods for treating this co-occurring condition of an individual who presents with an eating disorder as well as a substance use disorder.

I will also talk about strategies for sustaining motivation, that motivation is incredibly important when working with clients who have substance use disorders and eating disorders.

Also, treatment strategies for working with the client population concurrently, and at the end of the presentation I will provide a fair amount of information about mobile apps using them at the different types might want to use with clients and will leave time for questions and answers at the end of our time together.

Let's talk about eating disorders, some basic information for those of you not quite as familiar, they are among the most lethal of the mental health disorders, but the good news is they are treatable, they do impact the whole person and can have pretty serious psychological and medical impacts.
Anorexia nervosa, bulimia and binge eating are the most common, there are other listed in the DSM-V under eating disorders which is a new category since the last version of the DSM-V came out and those are avoidance restrictive food intake disorders, that can be a tongue twister but I got it out, you may more commonly hear mentioned are ARFID, that is someone with picky eating but more complex than that and if you have any questions about any of these specific diagnoses we can talk about or at the end.

The other category is the other specified feeding and eating disorders, these include atypical presentations that one might not think of when they think of me needing disorder such as atypical anorexia which is a person who engages in restriction just like the category of anorexia nervosa but they might not be in the underweight category.

Another example of other specified feeding eating disorders is nighttime eating syndrome.

One of the things that might not be as well known about eating disorders is they might not look like you would expect someone with an eating disorder.

There are stereotypes about eating disorders and some of you may have a visual of what someone with an eating disorder looks like, might be underweight Caucasian female, if that is what you think that is fine, that is what has been portrayed in the media and movies with individuals with eating disorders.

Their people were affected at all ages, different genders, ethnicities, shapes sizes and weights, sexual orientations, and socioeconomic status.

One of the things the latest version of the DSM-V did which I'm happy about is they widened the net inclusion criteria, removing things such as amenorrhea or stopping of natural cycle to be included forward disorder, because men also do have eating disorders.

When it comes to percentages, how many individuals have disorders it's about 20% of females and 14% of males that are impacted sometime by the time they hit 40.

I wanted to get and talk about how an eating disorder might present with your client that you might not expect.

The percentage on the slide is staggering to think about, the first occurrence of an eating disorder occurs before age 25 in 95% of individuals, so in terms of assessing and having a biopsychosocial discussion with the client is important for you if you're treating clients, to ask about feeding and eating, it is prevalent in adolescence and the typical age of onset is between 12 and 25 years of age.

Individuals with eating disorders experience a lot of disruptions outside of their own internal psychological well-being and medical well-being, it does interfere with their personal and family functioning and is a licensed family therapist one of the things I find incredibly important is including a system in the treatment of an eating disorder.
Eating disorders certainly do not occur in a bubble, is due substance abuse disorder presentations, it does affect other people.

I just wanted to point that out and we will talk about engagement of family and system in the treatment of this co-occurring presentation.

I mentioned this, individuals with eating disorders as compared to the general population do have increased risk for suicide and other medical complications.

They do typically require more frequent hospitalizations for suicidality medical couple occasions as well.

Lots of individuals are affected by substance use disorders, about 20 1/2 million in the last year, over the age of 12 experienced a substance use disorder and I wager that this statistic might be lower because of the pandemic – I'm curious to see the most recent data but definitely a large amount of people.

What is interesting is a small percentage of individuals with a substance use disorder receive any sort of specialty care. I will talk about effective treatments and being able to get specialist care being incredibly important for someone who has both an eating disorder and substance use disorder is a small percentage

When it comes to co-occurrence presentation, bulimia nervosa and anorexia with binge purge presentation are the two that are most related to substance use disorder diagnoses, one most related to his alcohol use disorder.

When we think about the comorbidity, is more challenges these individuals face, one of the things as a clinician, when our clients have any comorbidity there might be more challenges, but with this population in particular recovery tends to take longer and there are higher rates of relapse were both eating disorder and substance use disorder.

When I think about the elimination of a harmful substance or reduction in eating disorder pathology, it can be hard for client to focus on both and we will talk about treatment of both at the same time, but what we see is when someone reduces your substance abuse, eating disorder content to flareup and vice versa, it does present its own set of incredibly unique challenges and I, working with this population, you will see when someone is getting better in one area of what they are working on, they can tend to fall into that place of craving a substance or really wanting to use their eating disorder. We have to pay attention to those types of behaviors and I go back to that assessment piece, when you are engaging in a biopsychosocial to understand the complexity of both as notations.

Behavior is most common for someone who has a substance use disorder that we see our binge eating and purging behaviors them are binge eating is found among all substance use disorder presentations, understanding how client is eating can be helpful in understanding how to approach this presentation.
There is comorbid anorexia nervosa but not quite as common, what I will say is there are some substances that aid in weight loss, and individual with anorexia nervosa, not just anorexia but that as an example, might be drawn to that type of substance because it will fuel the eating disorder, not saying that is healthy or good thing to do, but in terms of the way the eating disorder functions, the individual with eating disorder or who has an eating disorder type pathology may be more drawn to those types of substances.

Overall, I will mention we'd used typically see either bulimia nervosa or some type of binge purge behavior that goes along with the substance use disorder.

Jessie I will hand this to you

>> JESSIE O'BRIEN: I have launched the poll so if you can give us your feedback, what is your familiarity level in treating comorbid eating disorders and substance use disorders more go ahead and select what is appropriate and don't forget to put any questions you have in the questions box – Q&A.

I will show and share the results

>> ELISSA MARTINEZ: This is what I was hoping for, having some familiarity and not even familiar at all treating this population, it is not unexpected that individuals who would attend this training would not have as much familiarity, we see one individual was very familiar, so curious to hear from you at the end of the presentation with any questions you might have.

It is one of those things that being able to attend a session like this and develop any sort of knowledge can be incredibly helpful so thankful you guys shared that in helpful for me in understanding how to address certain features of that co-occurring presentation as we move forward throughout this presentation.

NEDA is a great source such as NAADAC is a great or substance use disorders, this is a slide I have to share this with this group! 50% of individuals and might be higher this point abuse alcohol or other illicit drugs, in the abuses five times higher than the general population, if you have an individual with an eating disorder is a strong likelihood that they are also struggling with this cooccurrence presentation whether or not it is a full-blown diagnosis, there definitely having struggles with more than one area in their life, and the other comorbid presentations such as PTSD or major depressive disorder are also quite common – today we will focus our discussion on substance use disorders, and eating disorders co-occurring, but be aware that you might see a wide gamut, I work with clinicians and communicate all the time is clinicians who say my client has an eating disorder but that's not all they have – same with substance abuse or use, typically it does not exist on its own in terms of DSM appropriate diagnoses.

There is a strong –
There is a strong association as I mentioned, one of the things that is interesting that the literature states is that it actually starts in adolescence so I know I mentioned eating disorders typically onset is between the ages of 12 and 25 however that co-occurring substance use also tends to start around the same time.

It is one of those things that I mentioned, when you hear the client discussing bulimia nervosa which the main presentation of that is binging and purging behavior, some sort of compensation, you might want to also make sure to ask about their use of substances whom are with adolescents for those of you work with that population, they might not be 100% with coming in your initial conversation, so it is something to make sure to continually check up on and see if as you develop a rapport.

It is something to keep in mind and I will also say there is one study that I found interesting, done by a group, Ascandor – is an association for an individual consumes a lot of alcoholic beverages in one setting they are more likely to have or have developed an eating disorder so there is an association found with the amount that an individual drinks, and the likelihood that the either currently have an eating disorder or will develop one in the future.

I share that information from NEDA that 50% of individuals with eating disorder experience some sort of substance abuse or use, and on the flipside, individuals with a substance use disorder, over 35% of them will also experience an eating disorder in their lifetime.

There is a higher risk of developing an eating disorder for women, who have a lifetime alcohol use or nicotine use disorder, and what I will see in treatment centers and also discussion with my colleagues and peers, this is something that can be a real struggle because the alcohol use or the nicotine use can really be a way of managing anxiety, but the eating disorders also attending to manage through power and control of the food. One of the things I have seen in my practice and with other clinicians is if an individual is smoking cigarettes, at the beginning of the eating disorder treatment, we might talk about reduction in the use of nicotine but not an overall elimination because it can be really challenging and scary for an individual to think about completely getting rid of one of the behaviors or ways of managing their anxiety at the same time as they are reintroducing fear – food! Food which they fear.

One thing I will say, knowing more of a limited understanding of co-occurring substance use disorders, when an individual has an eating disorder and they are reintroducing foods that they may not have eaten for a long time, or increasing their calorie intake from 400 cal a day, they are having a very similar physiological response to that person who was being chased out by a bear – that fight/flight/freeze, it can be helpful in understanding that co-occurring presentation and how they may dig their heels into using nicotine, but the substance of choice as they are introducing food because it really is a complete fear risk response.
Those to disorders, alcohol use disorder and nicotine disorder are associated with competition behaviors that we do see, eating disorder might look the same even if the thing they are presenting problem might not include both.

I mentioned males because it is one of those areas that I feel in many ways has been neglected in the eating disorder literature in particular, males are at risk, who have an eating disorder or at risk for developing a substance use disorder.

For our clients were males you might be first thing you think about because that stereotype that may be embedded culturally, I know for sure before I started working with this population was not necessarily on the forefront of my mind, but make sure to talk to your client or males about their eating patterns in addition to their substance use patterns if that's what they are presenting with.

One of the assumptions that you can make and I have seen in my experience as well is supported by literature, is that for males they may want to suppress their appetite or regulate their emotions in ways that are different than females but it is still something that they can absolutely fall into and there is a stigma for males who have eating disorders.

There stigma with all mental health disorders but when I think of males especially younger males it can be incredibly challenging for them to be forthcoming about eating disorder.

The similarities, not that they are endless but you will see a lot of similarities between individual who has a substance use disorder an individual with eating disorder.

Coupled when you see that co-occurring presentation, a lot of the struggles they have don't stop at substance abuse it goes across the gamut of the struggle, and the way they respond.

What the literature indicates is there is a link between an individual depriving himself of food that looks very similar to the effects of the use of substances, and there is a very addictive quality in that feeling of restricting food. I have had numerous clients tell me especially who have co-occurring presentations that they get a really good feeling – not that they feel good because it doesn't feel good to be hungry – but a high they get depriving themselves of food that is very much mirrored when they are drinking or using a drug.

It is something that after they have been doing it for a while, they are conditioned to getting a reinforcing effect of the substance use as well as food deprivation.

Some individuals will even save up their calories to use a substance and restrict food. That can be in a credit will challenge and really working through that with clients, but you will oftentimes hear for certain clients that they want that feeling of the food deprivation as well as feeling of substance use and they are somewhat similar and how the client experiences them.
In terms of behaviors, behavioral dysregulation, for an individual substance use disorder there is emotional and behavioral dysregulation and engaging in risky behaviors, a lot of our clients with this code occurring presentation will engage in a lot of unsafe sexual experiences, that they might not do if they didn't have eating disorder and substance use disorder going on.

That is something clients will endorse if they have this code occurring presentation.

Another thing that you will see is their strained relationships with his individuals, it is not necessarily chicken or egg situation, because I have the eating and substance use disorder I have a hard time maintaining my relationships that are meaningful, or because of having not great relationships with my friends and family, you will hear something client north again, and when it comes to environment factors is a couple things I wanted to highlight for this particular population, but unfortunately environment will factor that can be a large common denominator although not experienced by everyone, who has a co-occurring substance use and eating disorder, it is some form of childhood trauma.

Is also seen with comorbid PTSD and eating disorders, a similar underlying factor, and in terms of parents we cannot blame parents they don't necessarily make an eating disorder or substance use disorder start, there have been some parental factors that occur with this comorbid presentation, a couple mentioned here in the slide, lower education levels among parents, what is interesting with the close internal relationships is when I'll read that at first and when you hear that permission thinking about comorbid presentation, close maternal relationship is not necessarily a positive thing that not necessarily, it can have an enmeshed presentation with a lot of clients with this presentation, and so a mom might think she is doing the right thing in supporting her child but given the money which is used to obtain substances or being on a diet with your kid can really feel this occurring presentation to emerge.

Another thing we have seen with regards to parents of children who have this co-occurring presentation is a poor modeling themselves of their relationship with food and substances.

Time and time again I have heard of clients telling me your mom – use moms as an example – but parents in total – yo-yo dieting throughout the life describing they don't like their body, they need to lose weight, and that is something that is instilled in the child and can be from a very young age, kids of young as second and third grade are now engaging in diet want to lose weight.

That is information that a child really unjust, so one thing about family therapy from a prevention checkpoint, but just something to think about, if you are working with a child with a parent wants them to see you as their clinician because they are struggling with food, it might be helpful to have a one-on-one conversation with the parent about the relationship with food.
Same with substances, if apparent seems to struggle with their own use or abuse, child definitely ingests that and can either go a couple of different ways, one of which is a complete avoidance of use of substances, or end up using them themselves.

There is a lot of literature about this out there, about moms focus on her own with weight and body shape, and those messages being instilled over and over again, sometimes a lot of times from a very young age does impact an individual and really sets the stage for that element of eating disorder and as a way of coping, a lot of the time substance use is introduced as a way of managing.

Just a couple of things about the environment.

Another underlying factor that we do see or an individual who develops a substance use disorder as well as eating disorder is a lifetime history of depression. One of the things about depression is that it is really uncomfortable for a client to experience in a couple of studies and meta-analyses substance use and disorders are really used as a way of distracting from the depression, which makes sense in working with this client population, they feel so much pain from feeling depressed they need some sort of relief or break, and being able to have an escape in the way of getting high or being under the influence, and depriving themselves of food or focusing trying to gain control over their bodies through the reduction of food which can then lend itself to develop end of a binge purge eating cycle as an example.

It really takes them away from that experience of the depression they have been experiencing and again oftentimes for a really long time throughout the life.

One of the questions I get all the time is, do I treat the substance use disorder first or the eating disorder first? My client only wants to talk about the eating disorder don't want to touch on substance use disorder, what do I do? Long story short here, treating both eating pathology and substance use at the same time are related to better outcomes, it can be uncomfortable when our clients really do not want to talk about one or the other, I think this is where really good psychoeducation can come in, and one of the caveats is that, if someone requires medical attention because of say anorexia nervosa they need to be hospitalized, or have an NG tube because they are really compromised, and or they need to go through detox to really engage in any sort of talk therapy or treatment that is interpersonal, that does come first. Definitely making sure medical and major psychiatric indicators are taken care of first, if somebody is suicidal, picking care of that – I know and Jumping points down – but this is a yes-and answer but I support treating both at the same time as does the literature, but we do have to really focus on someone safety and medical and physical needs first.

Once someone is stable, another thing literature emphasizes is a proper screening and assessment. Being able to figure out what type of substance use disorder and/or eating disorder an individual has, the challenge with a population like this can be not disclosing information about one or the other, and so you might not have a full picture of what individuals ensues looks like at the onset. But it is our job as clinicians to at least assess
for and develop an understanding at a minimum what they are willing to share with us at first.

There is a lot of relief in us as clinicians being able to normalize the co-occurring presentation, so hopefully you can use that information you learned today to be able to provide a really safe setting for clients to discuss this co-occurring presentation.

A sequential treatment of substance use disorder and eating disorder, or vice versa, is actually linked to poor treatment outcomes.

Something to keep in mind if there is hesitation on your part or on your agency’s part where you work to not treat both at the same time, know that it behooves you to consider treating both at the same time, and I will talk a little bit about how to treat them both at the same time, if you are that's great but what do I do next?

I will share some information about that in just a little bit.

I mentioned this before but with thinking about treating both at the same time I want to revisit that when you are treating both at the same time, oftentimes you will see an increase in the symptoms of one of the disorders, as the other improves so where I have worked with clients with eating disorders and co-occurring substance use disorders we have a track for those individuals with substance use disorders and they can either have an abstinence or harm reduction path, in working toward being open to absences but in their presentation they were not really willing to consider that which is okay we want to work with both at the same time.

One of the things clients will often report and I have seen, I am really handling eating disorder I am eating my meals and snacks as my dietitian and nutritionist have prescribed, but I think about is using my substance of choice and having ruminations, and this is something I would normalize but being able to have a conversation about both at the same time is really important because the behaviors can be interfering with the progress of the other.

One of the things that is important to make note of with this population is there is a higher risk of suicidality for an individual with a comorbid presentation so for lack of a better word if I am ignoring one of the disorders that the client is preventing such as substance use disorder, I am really doing a disservice and potentially the client, their suicidality or thoughts of harming themselves or killing themselves the increase.

When not treating both at the same time is a greater risk of relapse, and relapse is high among these populations in general, however, there is an exponential increase in that risk of relapse if not everything is being addressed.

Now we will switch to talk about some of the treatment approaches that have been seen to be effective for eating disorders and substance use disorders.

Is a lot more to be learned about treating this co-occurring presentation, one of the hypotheses as to why, one of the most common eating disorders in binge eating
disorders is only recently introduced as a diagnosis of its own, and the DSM-V, is more to learn and understand about, but what is great is we do have a lot of helpful information.

One thing I note, we will discuss the integration of mobile apps in the treatment, and what the apps in my opinion can do, what the literature indicates is it can really supplement and support the treatment you are doing with clients, it will reinforce his approaches, or the approach your agency is designed to work around and continue the care continuum outside of your sessions.

Even if they are at the residential level, being able to bring the tools they are learning in their moments of need when they are not in session.

A couple of evidence-based approaches I want to talk about, first of all, the treatment should really include a variety of therapies, if possible, this would be a best practice, and of course those of us who do not necessarily have groups or engage in family therapy, these are really suggestions, I'm not saying you can't do this work really meaningfully at an individual level, if you are able to integrate a group dynamic as well as family dynamic, it can be incredibly helpful for individuals.

One of the things that family therapy do is support the system that the client is involved with, outside of therapy, outside of a safe bubble of being supported by a clinician because they will go back into the real-world environment and we want to make sure what we are working on in session can translate into their environment at home.

If family can at least learn a little bit about how to support their child or loved one or partner, it can really be an indicator of sustained recovery or working towards sustained recovery.

Is a bunch of assessment tools that can be really helpful, I won't go too much to that, but there are screenings that are suggested to be used including the EDE-Q, and questionnaires for screening as well as alcohol dependent scale and the test for substance use disorders.

Reiterate what the literature pounds into, a proper assessment of an individual can be really helpful and for assessing their progress as they go through care with you.

There is evidence, and I will start with cognitive behavioral therapy, there is evidence for the use of CBT growth in a self-help capacity and incapacity in working with clinicians.

When it comes to using CBT, there is a couple of strategies that researchers have indicated that can be incredibly useful for this co-occurring presentation, and the first being self-monitoring.

Is lots of evidence, decades of evidence and research, that show clients keeping track of what is going on for the eating disorder when they are having meals and snacks, and for substance use disorder in their moments of craving and triggers to understand what is happening in that moment.
Understanding the thoughts and behaviors that come around it as well as how they respond to those cravings and experiences.

That is one piece of CBT can be helpful is assigning homework and have a client do things outside of session to keep track of how they are going.

If you do a quick Google search you see on line tons of CBT-based monitoring worksheets, and we will talk about why worksheets are not necessarily as supportive as a mobile app, in monitoring for clients, but you can get a good idea wide range of questions and applications of CBT and treating this co-occurring presentation.

Another thing that can be helpful that CBT supports is identifying risky situations. For an individual with co-occurring presentation, it is integral, if you do nothing else, something to think about whether client – will engage in or inevitably will be in a situation that will be incredibly triggering and we might consider high risk for them. One example that lots of example, going out to a celebratory dinner with family and friends. Is going to be actually a buffet of foods they have been avoiding or they have been a time in the past. There will be alcohol, and they are trying to live a life with no alcohol. Being able to work through the plan or being at that family party can really be a make or break and relapse of behaviors for a full relapse. Or a lapse at least.

I mentioned this in between the lines but let me clearly state, the CBT really should target both the substance use and eating disorder. Early on when I started working with this population, I leaned much more into one of the disorders, because it felt more of a focus for my client, however being able to integrate questions about the substance use my main focuses eating disorder, it can be much more powerful and normalizing for the client and shame reducing as well because we are putting it all out there, having them address all of the above at the same time.

That is a little bit about cognitive behavior therapy.

The next thing I want to talk about is DBT, dialectical behavior therapy.

It can be an incredible useful approach for individuals with co-occurring presentation, it has been investigated thoroughly for the use of co-occurring presentation, and elevator sentence about dialectical behavioral therapy, it really focuses on teaching emotion relations strategies, which we have talked about emotional dysregulation as found in this population is co-occurring presentation. Focusing on that emotional just relation as well as coping behaviors that can be used when an individual is feeling just regulated.

That applies for when an individual is sitting in front of a meal, they are really distressed about but think you might restrict or binge and then continue, eat the entire meal and binge afterwards so what are coping strategies an individual can use. It addresses not only the emotional just relation my DBT, but also the behavioral dysregulation that can come.
There was a study done that compared DBT implementation with a group that had just treatment as usual. DBT group had DBT plus CBT, and motivational interviewing, and the other group did not have DBT included. What the researchers found was DBT implementation did improve retention rates and also found other really positive results as a result of the implementation of DBT skills, which included better attitude toward eating so being more open and engaged to eating a more normalized meal plan as assigned by a dietitian. We also in that particular study – they, not we – a reduction in the rate and severity of substance use.

Being able to integrate DBT in the treatment of this comorbid condition really can provide auto beautiful supplementary results for you and your client.

I would strongly encourage you if you do not have familiarity with DBT by a workbook, or do a training on it to learn more about DBT, especially if working with clients with these types of presentation.

Relapse is really high among these populations, the findings that DBT study, with their follow-ups, not just during the study, it also found it to be helpful as they moved on from the treatment.

There are other approaches, that are supported in the literature, motivational interviewing, you might be more familiar with, what the literature indicates for this comorbid presentation, not just substance use, is that it can be helpful to use prior to implementation of a cognitive behavioral therapy approach, and it is really about focusing on increasing motivation for making these changes. Building insight into what the actual problem is, and just remaining engaged in the treatment process.

Lots of really useful tools and I – my assumption is some people on the call might be more familiar with MI in working with substance use but no it can be really helpful for an individual who also has an eating disorder at the same time.

I won't go too much into these other approaches, just straight behavior therapy, not so much focusing on cognition but focusing on making behavioral changes has been indicated to really help clients.

Community reinforcement approach, it really helps individuals focus on rearranging their lifestyles, and finding reward in things other than engaging in the eating disorder or substance use disorder, it is based on if you ever took psychology 101 in the day like me, feels like 100 years ago, East and operant conditioning where there is reward and punishment were either engaging in certain behaviors, or not, and it is really designed to increase behaviors healthy behaviors, in our case would be having meaningful relationships with individuals, who support a sober or harm reduction lifestyle as well as healthy relationship with food and body.

There are 12 step programs can be helpful with clients who present with eating disorder and a lot of the time these will happen concurrently. I strongly suggest all is happening concurrently, but for clients that I work with who present mainly with an eating disorder,
or that is their main focus rather, being able to introduce something like a 12-step program at the same time can be really helpful.

I had a client who that only did she struggle with a substance use disorder but so did her sister who was also in treatment for eating disorder prior.

One of the things I client in particular identified with was being able to be loved one with a substance use disorder rather than looking at her own substance use disorder so what we did was I first went with her to an Al-Anon meeting or supporter with an individual with an eating disorder she was nervous to go and so we were able to go together and we had her evening snack wrap before being able to feel supported by going to that meeting allowed for her to open up the idea of, okay, my sister substance abuse impacted me but also I'm hurting myself by using substances in addition to the harmful effects of my eating disorder.

I saw that in her case was more a supplement to the other approaches that I was using, but it was something that was really meaningful part of her process we were able to include and incorporate that she was able to take in step down to lower levels of care.

Client, we worked together at the residential PHP and IOP levels, she started the 12-step program I believe when she was at the PHP program, it really didn't have an awareness where is what their cognitive behavioral therapy was helpful in priming and prepping her, and getting to the place where she was open to thinking about engagement in a 12-step program.

For adolescence, it is important to include the family, the first line for clients with eating disorders, his therapy called family-based therapy, and this can be used for individuals who have a co-occurring substance disorder, but the main thing is really helping families understand and take control of how they can promote a supportive environment and family therapy, parents really took control of the feeding, while the client works on being able to be present in the moment.

This is a first-line approach for the treatment of adolescents. If you need or want to learn more about that reach out to me and we can talk more about the treatment of adolescents because it can be tricky especially if they are environment is not as supportive as would be desired.

Motivation is key. Without motivation all the stuff I mentioned can be really hard to approach and work effectively through.

I will tell people I have supervised in the past, we can have all these amazing tools at our disposal, the best type of treatment, but if we have not worked with our client to get to a place of feeling motivated, not going to do much good. I'm not just putting the onus on the client or becoming motivated, it is really about the clinician being that facilitator of motivation, of course it is up to the client to really experience that but we have a really wonderful ability to instill motivation in our client.
The work our clients are doing with this co-occurring presentation is incredibly challenging, I want to underline that and highlight and reinforce that, being able to initiate novation and sustain it is definitely a main part of our job. independent of the type of approach we decide to use.

We need to figure out and identify with our clients what type of rewards and reinforcers might they respond most to. It is not a one-size-fits-all, what one client might find to be motivating and rewarding, another client might not. This is something to consider for both in our sessions with clients, but also outside of clients, in between sessions, and also thinking about short-term motivators as well as long-term motivators. Why am I working toward recovery? Is it so I can be a better mom, is it so I can be able to walk down the street without having anxiety that I am walking past the bar that I used to get drunk at and binge and purge at? We have to really help our clients understand what those motivators might be in for other clients, thinking about younger clients, I have had clients feel so excited when I share with them ", words of affirmation, and with clients who really respond well to that when thinking about inside of session, every week I will print out a quote with a really pretty background that you can find online, to give to reinforce the work they are doing.

Not every client responds to that, some clients might like to be sent motivational videos were Ted talks, or have song lyrics pretty doubt that are rewarding or shared with them. Motivation, reinforcers rather really very, so this is where creativity can come and it can be fun for us as clinicians too.

Another thing I want to mention is use of humor, that might be an understated thing because this work is challenging but being able to use some of our Humor, it might reinforce them wanting to come back to us so we need to talk about serious things in session, but I can also be helpful.

Moving on, thinking about coping skills that clients can use to keep up with the work. Being able to find things get clients from one triggering situation or challenging situation to the next can help them remain motivated because if they are trying one coping skill that is not working over and over, I'm certain my motivation would probably decrease. Being able to find a coping skill or coping skills, a set of them, that will be helpful for the client that they respond to and be really helpful. There are tons of coping skills specific to the treatment of substance use disorders and eating disorders, that can be really helpful for clients.

One example is urge surfing, but can also look like crave surfing for client who has this co-occurring presentation, so talking about how to use an urge surfing coping skill, riding the wave and not letting the craving or urge takeover. That can help continue their motivation.

Is a group who came up with a couple aspects essential to people self-motivation, so I just wrote down, these were the three pieces that they found to be most widely supported by research in helping individuals maintain motivation.
The first being autonomy and how they discover that was a feeling of agency and being able to act in accordance with one's goals and values.

Being able to foster that for our clients can be important with keeping them motivated for this work.

Next is competence. They described that as being able, feeling able, and effective so no one likes to feel like they can't do anything even if they are at a place where they are not doing so well, being able to support our clients and continuing on and feeling like they are competent in something that can really serve as a motivator as well.

Being able to complete a CBT homework assignment in a mobile app for example, us being able to create something and a goal for them that is measurable, achievable, it can be incredibly helpful for clients.

And relatedness feeling connected to others and having a sense of belonging.

I interpret that as being able to feel connected with clinician, but also with individuals in their life so if individuals feeling incredibly isolated, you might refer them to a virtual community meeting of some kind, or if they have not spoken to her really good friend in a while, suggesting a goal, maybe even in one of their apps if you are linked with him, with the self-monitoring app called their friends, Jane, tomorrow, and that would be really helpful.

Once we have identified some ways to feel motivated, it is important to also link these two these motivators to actual behavior changes, so providing examples that can really lead to a lifestyle of reduction of substance use and also a more normalized healthy relationship with food and body that can really be helpful in the elimination of certain behaviors.

So, looking at reasons to recover and having individuals look at examples of ways they have been able to align their values and reasons they want to recover.

Why are clients motivated, and considering not only their individual or intrinsic motivators but also extrinsic motivators. If a client is really focused on how recovery benefits himself, I would encourage you as a clinician or supportive person to talk about their interpersonal rulership, things they might've done in a job or school setting, they might be so far removed because they are so entrapped in the eating disorder and substance use disorder it might be hard for them to see that.

With that said – I'm going to talk about making treatment accessible. We live in a wonderful day and age, if I can say that, there is excess ability to support anywhere a client is anytime, I don't know about you but for me my client and myself, I have my cell phone typically within arm's reach, whether I like it or not sometimes, it is just the reality.

We want clients to be able to self-monitor and keep track of what is going on in between sessions, and being able to do that, and I will talk from the context of using mobile app to do self-monitoring, it can really help us to understand what is going on for clients and
their moments of need, and being able to have a client using mobile app to engage in check-in's, CBT-based check-in such as with regards to thoughts, dysfunctional thoughts or even diary, free text and of thought, to their habits, eating habits, what type of behaviors are they engaging in regarding meals and snacks, any substance cravings or triggers to use, that might come up, I can be really helpful to use that information in session.

Being able to routinize that, make it easy for clients to do can really help make them make progress or help them into recovery place on the eating disorder and the substance use disorder.

In addition to having the data of what is going on when they're having dysfunctional thoughts and how is the eating looking it can also help self-monitoring and help increase awareness what is going on when they are feeling certain emotions, how are they acting or behaving, who are they turning to, what are they turning to, is it healthy or unhealthy, with the eating disorder behaviors.

Self-monitoring allows for us as a clinician in the treatment team to understand what is going on in the moment, even if we are not looking at their mobile apps whether inches are everyday all day, which we should not do because we need our own boundaries too, but it can be helpful for not only us as a treatment team to have that data but also keep the client knowledgeable of what is going on, and also knowing the clinician, what you will see, it is ordered of the things I go back to shame, is a reduction in shame in being able to use self-monitoring data, and to feel discussions rather the client feeling like they are holding onto the secret of what happened in the past weeks and the, but if they use a mobile app that connects with her clinician, clinician, another clinician sees what is going on so it can really help let their guard down.

Self-monitoring also reinforces the changes that a client has made, a lot of apps, there are affirmations and other things within the apps that support the work that a client is doing and help them to continue to engage in their work, they earn rewards or mile stones, in the apps, paying particular attention to mobile apps and the support of self-monitoring.

One of the things a group – I will not try to pronounce – being able to generalize skills you're working with in session, some apps do have coping skills and behavioral skills, if they are being reminded to use those coping skills if they have those accessible in the challenging moments they are more likely to use them rather than going through a mental Rolodex of I know Elissa said urge surgery would be helpful but if they are in a heightened state of emotional disfiguration which is quite common among this population, it might not be as accessible as if they have something concrete like their cell phone with an app that has cognitive skills listed.
And overall, the client is not keeping up with the work in between sessions, whether that is paper-based or in and out, they are likely to not have as good of outcomes when it comes to their overall treatment.

Being able to find any way we can make this easier for our clients because they are doing incredibly challenging work, is something that we should pay mind to.

We know that client should self-monitor, I think I have made that clear, the literature supports that, I wanted to talk through points made in literature.

One is that doing homework, engaging in self-monitoring sessions is associated with better outcomes. Just from a practical standpoint it makes sense that if a client keeping track of their urges and cravings, their eating disorder pathology, and they are able to share that with their clinician, is going to be much more meaningful in session progress made because we are looking at exactly what is going on with the client.

I have many times where clients do not adhere to their homework, for a lot of reasons, they will come in and say, X, Y, and Z experienced this weekend I thought about using substances all day every day, restricted and binge purge times, and putting together a puzzle that does not necessarily make sense!

As compared to someone who is doing their homework, monitoring, we can look and check and see where the different patterns and where an individual was when they were having certain urges to engage in binge purge episodes, or where they walked by that they were having a really strong urge to use a substance is much more helpful and actually creates a better flow when it comes to doing actual work in session.

More consistent monitoring is, the better the treatment outcome, so if the client is able to, or the time you are working with him track of what is going on, you will see better outcomes rather than someone who for a week or two is off. One piece of language I use, which I pulled from some of the trauma work that I do with clients, if a client is not monitoring, I might call it avoidance. Avoidance equals not getting better. For some clients that language might appeal to them, so think about that word is a way of being able to potentially motivate them to engage in more monitoring.

A couple point here about eating disorder and substance use disorders, keeping track of what is going on with food intake can decrease binge eating behaviors, even if there is no other intervention period just that self-monitoring can decrease eating disorder behaviors taking away any other professional interventions, which should still be used and of course you'll see better outcomes with that.

For individuals who describe themselves early in recovery from out and alcohol use disorder, we do see really good self-monitoring compliance, there is no coincidence for someone who is engaging in self-monitoring, is likely to remain in recovery. Not all because there are highly rates of relapse, but putting themselves in a better position.
The problem is that I alluded, best practice from decades and decades is not necessarily engaging exciting, feels outdated, an individual keeping track of their meals and snacks and also thinking about ways to engage in self-help meetings, that sheet of paper can get lost in the compliance rate is really poor or self-monitoring, it is not as good as if there's something on a mobile app with reminders and helps them keep track of what is going on.

There is really good news! We can provide the support I have been mentioning in apps, and allow for clients to connect with us and have their data at our disposal when we are working with them in session, that they are updating between sessions.

It is interesting, the client, our clients' individuals in general, were using apps, and smartphones were a variety of reasons, and one of which was that research on mental health issues or other stigmatized issues are much higher on someone's cell phone then on someone's desktop. Individuals are going to their cell phones to understand what is going on with them, or curiosities about certain struggles they might have.

In general individuals in the United States are spending way more time on their phone apps that they are watching TV, so something that just as a general population we are more joint to.

How do I interpret that? If a client is more likely to research something on their phone and go to an app then you lots of other things, let me figure out how to incorporate an app in their work that they will be more likely to engage and use rather than a paper-based monitoring or worksheet type intervention.

A grand majority of US cell phone users do use smartphones, it is not everyone, but a grand majority of 81% are using smart phones.

Just something to keep in mind this is something that is actually used.

When it comes to making about clients with eating disorders, being able to self-monitor around meals and snacks is important, even being able to take photos of meals or log what is going on during a meal in the moment is important, so 95% of individuals do use their phones in restaurants, so not outside of the social norm at this point for individuals to take the phone out, so if someone does not need to know who they're sitting across the table from if they are logging something with, in relation to the eating disorder or uploading a photo into their social media of the desert they find unusually appealing.

Is less socially confronting then say taking out a worksheet their clinician asked them to complete.

Teams, if any of you are parents to teens or have teams in your life, based send an average of 70 texts per day, and the moral of the story, smart phones and apps are commonly used.

And so why do we want to integrate apps into client care? There's a lot of reasons. Some of which I have alluded to, they can use them anywhere, it can be in a foreign
country, they can be in any state, anyplace, anytime, they can use the app. It is not something that they have two remember like a folder of sheets of paper.

There is transparency in what a client tends to report into a app. It really allows for outcomes in progress, no having to look out another sheet of paper to see what is going on – it makes things more clear for the client and provider.

A provider is becoming informed of what is going on, and can also allow for really personalized care. There are apps that have a variety of features involved, and so we as clinicians can be informed about what type of app we want to use, and also furthering that, when I am deciding on an app that I deemed to be helpful for certain client, I can facilitate forward progress for this client in this presentation.

I’m going to take his water and headed over or another poll question!

>> JESSIE O’BRIEN: a reminder we’re getting lots of good questions in the Q&A box so go ahead and like any that you want is the answer in the poll is open so you can give us your votes.

Let's give it about five more seconds, get your vote in, and I will share the results, and they will share the results, it's not letting me share the votes

91% said false!

9% said true

>> ELISSA MARTINEZ: It is one of those questions, when it comes to the clinical presentation of someone with coworker and eating disorder and substance use disorder, after not intended as a replacement for therapy or professional intervention however for those 9% who answered that it can be used, self-monitoring can be a really wonderful steppingstone to receive professional care and when someone is more in a maintenance phase be really helpful to use apps.

In general answer I would say is apps really should not be a replacement or professional care.

In those intermittent times when it is more maintenance, can be used because it is powerful to self-monitor. I appreciate the honesty in your answers.

Now, I decided I want to use an app with – how to introduce it and talk about it? I am mindful of the time and I will try to leave at least several minutes to discussion, I’m looking forward to hearing those questions.

I encourage you is talk about the expectations or use of apps. Is it something that a client should be checking in on daily, hourly, it really depends on the type of app want the client to use.
For example, if I'm working with a client really needs to keep track of their meals and snacks which is most of the population, I'm going to attempt to log their meals and snacks in and out at a minimum and I will talk about other things I might want them to check in and including your substance use cravings and I might want to say, you really struggle in the evenings, it would be helpful to do a meditation at night.

I would also if using an app where you are linking with the client, which is available, you might want to explain I am only using this data in session or to correct before but I'm not available 24/7 unless you are a true DBT clinician where you might make yourself available, this would probably be the typical or suggestion that would make.

I would also normalize and address any concerns client might have about having mobile app, get lots of feedback from clients and clinicians working with clients who struggle with food and eating, and substances if used apps and other social media that have really fueled eating disorder substance use disorder.

Focus on an app that does not view all views, so talking about how to pick the correct apps or app on your client use but normalize the concerns because if they really felt drawn to some of their behaviors or more likely to use because of an app or social media, finding one that is evidence-based and compliant HIPAA compliant will be important.

I will also talk about the benefits for the client, why is this helpful for you why will you like doing this? First of all being able to illuminate and paper appeals to a lot, having support in their moments of need and between sessions, it really gets a client excited using until rather than saying, downloads out, goodbye, an important part of introducing mobile technology to client.

I would also strongly encourage having your client download the app during session start to do some sort of monitoring or use in session with you.

Getting them to use the tool to be able to complete some sort of check-in, if that is the type of app you want and use, or set up how many days sober they have been can really feel good to get that progress started because the next thing you know is if you have not done a week or two weeks and the client has missed out on entering that really helpful data, being able to take a few minutes in session to talk about that can be really helpful.

I would also reinforce about how the app will be used in your work, being really specific about either checking in on this and see how you are doing or interact with you in the app, being clear about how often engagement should be expected if it is an app that you are linking with them on, and again the type of check ins you would expect to see from them.

And normalizing if there has been a day or two, that will help more than a client logging, so being able to support them in keeping up with that work in the app if that is something that will be integral to your work with them.
I would talk about any sort of expectations you have around incorporating technology, if you have some sort of policy and procedure, at your agency including information about that mobile apps, taking photos, if his other clients around, or in groups what that looks like. When it is appropriate to have their phone out or not. Writing can be helpful for clients to see.

As mentioned, when clients in treatment reinforcing, this is not replacing therapy, it does not mean and suddenly not see you if it is something they need, but explaining this is something that is supporting and augmenting work they are doing.

And talking about those technology boundaries, I'm am not going to be available and what I described to clients and explain to other clinicians who asked me the same, I explained that like an email I am not obliged to see that 24/7 and that is how this app will be used? Apps do have the ability to have do not disturb ours, or office hours, so something I would strongly encourage you to do if you're using a mobile technology, being clear so there is no – I thought you would check this all day everyday – and being able to make that very clear for client.

>> JESSIE O'BRIEN: We have about three minutes before we have to wrap up

>> ELISSA MARTINEZ: I will bust through a couple things.

Clients in general are much more connected with their treatment providers using apps, they feel that they can stay on track more or a lot better depending on the client, and importantly they do feel held accountable and find it easy to use.

There are some concerns the clients may mention, these are things that I would work to normalize that they might feel more preoccupied, and at first, they might as with any type of treatment, but let them know that is something that tends to go away, and something to revisit in session with client.

I would talk about reaches of data which I will get into because I only have a minute and 1/2, and normalizing they may have a fear of judgment, but this is to help you in the work you are doing.

A couple of apps that can help support treatment in ways they can support treatment, the first you see is some apps have integration of self-monitoring for eating disorders and substance use disorders!

Is a place you see on screen client can trigger, or craving and go through CBD monitoring to explain what is going on.
Also being able to access EBT, CBT and acceptance and commitment there be, coping skills the palm of their hands as well as being able to link to the treatment team to share that information which is something that I mentioned or might you might also want to share an app or meditation with clients that have guided meditations, sleep stories if they have trouble sleeping, mindfulness topics and stretching and movement programs.

And there's also features that include tracking days of sobriety, pledge tracker, while I do this and reasons why I quit reason why I am recovering.

I would like to go over some basics about looking out of what you should look out for when suggesting mobile apps. I would try the app out at first, download it and see what it is about, do a little bit of research in the literature and see if this app supported and does it align with your therapeutic approach, does it align with evidence-based approaches? Is there any peer-reviewed research that has been done on the tool or tools made by the creators? Looking into safety and security standards such as HIPAA and HITECH Act compliance.

Jessie, I will hand it over to you!

I hope I didn't go too far over my time!

>> JESSIE O'BRIEN: we might have time for one question, we will mail these questions to you as well, so you can answer them or post them on the website

how do you tell a good app from a bad app help clients judge?

>> ELISSA MARTINEZ: One of my first lines of defenses is download the app myself and also go to NAADAC or NEDA, those groups that support clients with eating disorders and substance use disorders, so that would be my first line of defense is checking the app out myself, and also Google Scholar see if this app has been looked at and that can be helpful but definitely looking at yourself

>> JESSIE O'BRIEN: Okay – what would be the very first step treatment while somebody over age 65 who has had an eating use disorder for someone who never sought treatment of any kind?

>> ELISSA MARTINEZ: I have had this presentation before, the first thing to do with this client would be in general really work on reducing the shame because especially clients who present alternate feel really bad because a lot of the time the onset is much earlier, if they are engaging in treatment at higher levels of care they tend to be much older
than other clients, and finding ways you can feel connected to them and some of the apps you might be able to send affirmations to them if they are someone who might use the technology, but I think really that therapeutic alliance, making them feel supported and heard, and not embarrassed or ashamed for seeking treatment because it takes so much bravery would be my first step and feel free to email me if you have any more questions about that – I can provide more information

>> JESSIE O'BRIEN: I think we are out of time, so thank you so much, and if you want more information about the recovery that you saw on the previous screens that is for substance use disorders or the recovery record app or eating disorders this is the link you to go to that, used by treatment providers to keep clients engaged and develop interventions to appoint and deliver modern data for clients.

There is a webpage where you can get more information or make a reminder.

Every NAADAC webinar has everything you need to know on the webpage where you registered update on the CE quiz we are having a bit of a snafu with our quiz software now and we have put in a ticket to get it fixed and they’re working on it, you will not be able to access the CE quiz but after so I apologize so please try again tomorrow, I know it is a pain and again I'm sorry, but we are working to fix it and we will extend the live webinar on the certificate through the weekend so you have time to take it so I apologize for the inconvenience.

You will be able to access the CE quiz tomorrow.

Make sure to use the instructional guide if this is your first time getting a certificate or make upcoming webinars, September 10 we have part seven in this series with Thomas Britton and Mark Turner, and September 15 a Gestalt view of the Latino experience with substance use disorders, hopefully you guys can join us for that.

Also, NAADAC annual conference is October 20-30th, and interactive, whole conference platform, you can get in a virtual format but is accessible you do not have to fly anywhere so if you are interested save up $251 that rate ends September 15!

We are also doing pre-conferences for the conference on the Fridays leading up to the conference, October 8, 15, 22, we have a theories practice in skills, Spanish-speaking pre-conference on October 15, a criminal justice one and cannabis and nicotine that use disorders so if interested six CE, take a look at those, in the last in our advancing awareness of LGBTQ care series is on September 17, it is a dynamic and interesting lively presenter series and I hope you guys will join us and if you have not seen the rest of them I recommend you take them on-demand.

An awesome series.

And we also have another specialty online training series, this is faculty online training series we did on earlier this year, then this one is wellness and recovery in the addiction
profession all available on demand, lots of material and supporting recovery with different wellness practices.

If you are not a member of NAADAC yet please join us, and that is it!

Happy Friday before Labor Day and reminder, a short survey will pop up please take your time gives your feedback, we will go to the present or, stay linked with us on LinkedIn, Facebook and twitter and thanks again Elissa take care everyone

>> ELISSA MARTINEZ: Thank you and have a great weekend